STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

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Testimony of Michael Norko, MD
Director of Forensic Services
Department of Mental Health and Addiction Services
Before the Judiciary Committee
February 23, 2011

Good afternoon, Senator Coleman, Representative Fox, and distinguished members of the Judiciary Committee. I am Dr. Michael Norko, Director of Forensic Services for the Department of Mental Health and Addiction Services (DMHAS), and I am here today to speak in **support of H.B. 6276, An Act Concerning Competency to Stand Trial and HB 918 An Act Concerning The Sexual Assault Of Persons Whose Ability To Communicate Lack of Consent is Substantially Impaired.**

HB 6276 is a DMHAS proposed bill before you today and the purpose of this bill is to permit consideration by the court of the least restrictive alternative placement for individuals hospitalized for mental health treatment to restore competence to stand trial. When a court receives an evaluation report of a defendant's competence to stand trial that recommends that the defendant is not competent to stand trial but may be restored to competence to stand trial with treatment, the court must make a determination regarding the "least restrictive placement appropriate and available to restore competency," according to Sec. 54-56d(i). The court has available to it the recommendation of the evaluators in making this determination, since we provide information about least restrictive placement for all defendants who are recommended not competent to stand trial but restorable.

On average for the last 3 calendar years, we have evaluated approximately 590 defendants per year for competence to stand trial, and made recommendations of findings of not competent to stand trial in about 47% of them, with 40% of the total defendants evaluated being found not competent and restorable (237 persons per year, on average). Each year, on average, approximately 200 individuals were ordered placed in a DMHAS inpatient setting for restoration treatment. Approximately 15 defendants per year were ordered to DMHAS outpatient restoration in consideration of the least restrictive placement available and appropriate for the restoration effort. (A smaller number of restorations are ordered in other agencies from among the defendants evaluated by DMHAS. In the last 3 years, the annual figures have averaged: 5 outpatient placements with the Department of Developmental Services, 10 inpatient placements with Department of Children and Families (DCF) and 7 outpatient placements with DCF.)

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The DMHAS Division of Forensic Services is interested in facilitating greater use of outpatient restoration as ordered by the courts. For example, we have a pilot project beginning in New Haven this month, which will use a structured manual approach to provide restoration services with the availability of a day-monitoring setting in the community. We hope to increase the number of recommendations we are able to make to the court for outpatient restoration as a result of this pilot, as well as improving the prospects for such outpatient restoration to be successful..

For the 88% of incompetent defendants receiving restoration orders who are sent to inpatient treatment, there is no statutorily available alternative for such persons to be returned to the community to continue with restoration treatment even when circumstances warrant such a transition. It is possible that an individual can improve sufficiently in the hospital so as to no longer require an inpatient level of care, but still not be restored to competence to stand trial, particularly in a complicated trial scenario.

This bill, if adopted, would allow the courts to consider situations in which this might occur. Judges would then be able to order that a defendant be transferred to outpatient restoration treatment in cases where the court finds that the individual is making progress toward attaining competency, and that inpatient placement is no longer the least restrictive placement appropriate and available to restore competency. The bill thus permits the court to make the same determinations about conditions of release as occurs during the initial consideration of outpatient restoration under Sec. 54-56d(i). The proposed language for this additional consideration is drawn from existing language in 54-56d(i). Passage of this bill would allow us to apply the principle of least restrictive placement to defendants who have been placed in inpatient treatment and are doing better clinically and making progress toward restoration of competence to stand trial.

I also wish to speak briefly **in support of Raised Bill 918, An Act Concerning the Sexual Assault of Persons Whose Ability to Communicate Lack of Consent is Substantially Impaired.** From our perspective, this bill accomplishes two important changes: 1) it removes most of the last remaining statutory references to persons as "mentally defective"; and 2) it removes the stigma of disability from the definitions of sexual assault, instead referring to the actual key issue, which is the victim's impaired ability to communicate lack of consent to sexual activity arising from any mental or physical condition. Thank you for the opportunity to address the Committee on these important bills. I would be happy to take any questions you may have at this time.